KENTUCKY BOARD OF NURSING
312 Whittington Parkway, Suite 300
Louisville, KY 40222-5172

# PRELICENSURE NURSING PROGRAM (PON): PROGRAM ADMINISTRATOR RECORD

*To be submitted to KBN within 30 days of appointment*, along with current CV and letter from the hiring College official

**Submitted By:** _____ (Name of College/University- DO NOT ABBREVIATE) **Campus/Location(s):** _____

**Type of Program:** ☐ BSN ☐ ADN ☐ MEEP: PN & ADN (Multiple Entry and Exit Program) ☐ PN

**Type of Appointment:** ☐ Administrator ☐ Interim -Administrator

**Name of Appointee:** (name as it appears on their nursing license)

_____ (Last Name) _____ (First Name) _____ (Middle Name) _____ (Maiden Name)

**Social Security #:** _____ **Employment Status:** ☐ Full-Time ☐ Part-Time

**License #:** _____ **Compact License:** ☐ Yes ☐ No- **State of Primary Residence:** ____ **Expires:** _____

***Must hold an unencumbered current license, privilege, or temporary work permit to practice as a registered nursing in the Commonwealth of Kentucky from the date of employment.***

**License has been verified on line at the appropriate Board of Nursing:** ☐ Yes ☐ No

**Appointment Date (mm/dd/yy):** _____ **E-Mail Address:** _____ @ _____

**"Earned" Nursing Educational Degrees: (Check all that apply)**

☐ Diploma - School Name: _____ YR: ____
☐ Associate - School Name: _____ YR: ____
☐ Bachelors - School Name: _____ YR: ____
☐ Masters in Nsg-School Name: _____ YR: ____
☐ Post Masters Cert.: _____ YR: ____
☐ Doctorate in Nsg/ Other Field: YR: _____

Date of Initial licensure as RN: ____/____ (Month / year)

**Additional "Earned" Non-Nursing Education Obtained:**

College/University _____ Degree ____ Degree Awarded Yr ____

**For RN programs:** A minimum of an earned masters or higher degree in nursing
**For PN programs:** A minimum of a baccalaureate or higher degree with a major in nursing

**Currently enrolled at:**

College/University _____ Degree Pursuing ____ Expected Graduation Sem./ Yr ____ # credits earned _____

## Answer the following questions with respect to this appointment.

**The Kentucky regulations dictate that a program administrator shall have the following qualifications:**

| | RN & PN Programs |
|---|---|
| 1 | **A minimum of five (5) years of nursing experience within the immediate past ten (10) years and demonstrated leadership experience (Provide detail in the row below pertaining to formal and informal experiences that would enable competent performance in the administrator role)** |
| | ***Detail:*** |
| 2 | **A minimum of two (2) years of full-time teaching experience at or above the academic level of the program of nursing (provide specific time frames and responsibilities)** |
| | ***Detail:*** |
| | **PN Programs (only)** |
| 3 | **A current knowledge of nursing practice at the practical or vocational level (provide narrative on how this has been accomplished)** |
| | ***Detail:*** |

***I certify that the information contained herein is correct and complete to the best of my knowledge.***

_____ **Signature of Appointee** _____ **Date**

***Don't forget to include:*** **copy of current CV AND notice on college letterhead from a college/university official**

**Office Use Only: Review Date:** _____ **By:** _____ **KBN #:** _____ **Entered:** _____
Codes: ☐ None Other: _____ Letter Sent: ☐ Education Needed ☐ Name Change ☐ License other state NG/lh

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# PRELICENSURE NURSING PROGRAM (PON): NURSE FACULTY RECORD

**(Nurse Faculty are defined as those individuals that will be teaching in the classroom may or may not include clinical/lab)**
*To be submitted to KBN by PON Program Administrator within 30 days of appointment.*

**Submitted By:** _____ **Campus/Location:** _____
Name of College/University- DO NOT ABBREVIATE

**Type of Program:** ☐ **BSN** ☐ **ADN** ☐ **MEEP: PN & ADN** (Multiple Entry and Exit Program) ☐ **PN**

**Name of Appointee:** (name as it appears on their nursing license)

_____
Last Name First Name Middle Name Maiden Name

**Social Security #:** _____ **Employment Status:** ☐ Full-Time ☐ Part-Time

**License #:** _____ **Compact License:** ☐ Yes ☐ No **State of Primary Residence:** ____ **Expires:** _____

**License has been verified on line at the appropriate Board of Nursing:** ☐ Yes ☐ No

**Appointment Date (mm/dd/yy):** ____/____/____ **New position:** ☐ Yes ☐ No- Replacing (name)_____

**E-Mail Address:** _____@_____

**"Earned" Nursing Educational Degrees: (Check all that apply)**
**(NOTE: Nursing faculty must have a minimum of two (2) full-time or equivalent years experience as an RN within the immediate past five (5) years)**

☐ Diploma - School Name: _____ YR: ____
☐ Associate - School Name: _____ YR: ____
☐ Bachelors - School Name: _____ YR: ____
☐ Masters in Nsg-School Name: _____ YR: ____
☐ Post Masters Cert.: _____ YR: ____
☐ Doctorate in Nsg/ Other Field: YR: _____

Date of Initial licensure as RN: ____/____
Month year

**BSN Programs:** MSN required upon appointment.
**ADN Programs:** BSN required upon appointment & MSN obtained within 5 years ***or*** BSN + Masters in related field and 18 graduate nursing hours.
**PN Programs:** BSN required at time of appointment.

**Additional "Earned" Non-Nursing Education Obtained:**

| College/University | Degree | Degree Awarded |
|---|---|---|
| _____ | ____ | Yr ____ |
| _____ | ____ | Yr ____ |
| _____ | ____ | Yr ____ |

**Currently enrolled at:**

| College/University | Degree Pursuing | Expected Graduation | # credits earned |
|---|---|---|---|
| _____ | ____ | Sem/ Yr ____ | _____ |
| _____ | ____ | Sem/Yr ____ | _____ |

**Areas of Clinical Specialty:** _____
**Teaching Responsibilities Include What Specialties:** _____

## Answer the following questions with respect to this appointment

**The Kentucky regulations dictate that nursing faculty meets the following criteria.**

- Minimum of two (2) years full time or equivalent experience within the last five (5) years? ☐ Yes ☐ No
- Preparation in educational activities in the area of teaching and learning principles for adult education, including curriculum development and implementation: ☐ No ☐ Yes- How acquired: ☐ Faculty development ☐ CE offerings ☐ Academic Courses ☐ Other: _____
- Graduated from a college/university that is accredited by the Department of Education: ☐ Yes ☐ No
  Has graduation been confirmed by an official transcript from the degree granting institution? ☐ Yes ☐ No
  If an ADN Program and working on MSN, provide a copy of plan for degree completion.
- Prior teaching experience? ☐ Yes- Where: _____ ☐ Faculty ☐ Clinical
  ☐ No - Name of assigned mentor _____
  ☐ Copy of educational development plan attached

***I certify that the information contained herein is correct and complete to the best of my knowledge.***

_____ _____ _____ _____
**Signature of Appointee** **Date** **Signature of Nurse Administrator** **Date**

**Office Use Only: Review Date:** _____ **By:** _____ **KBN #:** _____ **Entered:** _____
Codes: ☐ None Other: _____ Letter Sent: ☐ Education Needed ☐ Name Change ☐ License other state NG/lh

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# PRELICENSURE NURSING PROGRAM (PON): CLINICAL INSTRUCTOR RECORD

**(Clinical Faculty are defined as those individuals that will be supervising students in the clinical or lab areas)**
*To be submitted to KBN by PON Program Administrator within 30 days of appointment.*

**Submitted By:** _____ **Campus/Location:** _____
Name of College/University- DO NOT ABBREVIATE

**Type of Program:** ☐ **BSN** ☐ **ADN** ☐ **MEEP: PN & ADN** (Multiple Entry and Exit Program) ☐ **PN**

**Name of Appointee:** (name as it appears on their nursing license)

_____
Last Name First Name Middle Name Maiden Name

**Social Security #:** _____ **Employment Status:** ☐ Full- time ☐ Part- time

**License #:** _____ **Compact License:** ☐ **Yes** ☐ **No** **State of Primary Residence:** ____ **Expires:** _____

**License has been verified on line at the Board of Nursing website:** ☐
**License is Active & Unencumbered:** ☐ Yes ☐ No, explain: _____

**Appointment Date (mm/dd/yy):** ____/____/____

**New position:** ☐ Yes ☐ No- If no, replacing (name) _____

**E-Mail Address:** _____@_____

**"Earned" Nursing Educational Degrees: (Check all that apply)**
**(NOTE: Clinical faculty must have a minimum of two (2) full-time or equivalent years experience within the functional area as an RN within the immediate past five (5) years)**

☐ Diploma - School Name: _____ YR: ____
☐ Associate - School Name: _____ YR: ____
☐ Bachelors - School Name: _____ YR: ____
☐ Masters in Nsg-School Name: _____ YR: ____
☐ Post Masters Cert.: _____ YR: ____
☐ Doctorate in Nsg/ Other Field: _____ YR: ____

Date of Initial licensure as RN: ____/____
Month year

- All Clinical Instructors must be RNs.
- For Registered Nurse educational programs, the educational preparation of the clinical instructor shall at least equal the level of the appointing program.

**Additional "Earned" Non-Nursing Education Obtained:**

| College/University | Degree | Degree Awarded |
|---|---|---|
| _____ | ____ | Yr ____ |
| _____ | ____ | Yr ____ |

**Currently enrolled at:**

| College/University | Degree Pursuing | Expected Graduation Sem/ Yr | # credits earned |
|---|---|---|---|
| _____ | ____ | ____ | _____ |
| _____ | ____ | ____ | _____ |

**Areas of Clinical Specialty:** _____

**Clinical Teaching Responsibilities Include What Specialties:** _____

**Answer the following questions with respect to this appointment**

**The Kentucky regulations dictate that nursing faculty meets the following criteria.**

- Minimum of two (2) years full time or equivalent experience within the designated clinical functional area within the last five (5) years? ☐ Yes ☐ No
- Graduated from a college/university that is accredited by the Department of Education: ☐ Yes ☐ No
  Has graduation been confirmed by an official transcript from the degree granting institution? ☐ Yes ☐ No
  If an ADN Program and working on MSN, provide a copy of plan for degree completion.
- The clinical instructor shall function under the guidance of the nurse faculty responsible for a given course. The faculty member that will be overseeing the course and clinical instructors is: _____

***I certify that the information contained herein is correct and complete to the best of my knowledge.***

_____ _____ _____ _____
**Signature of Appointee** **Date** **Signature of Nurse Administrator** **Date**

**Office Use Only: Review Date:** _____ **By:** _____ **KBN #:** _____ **Entered:** _____
Codes: ☐ None Other: _____ Letter Sent: ☐ Education Needed ☐ Name Change ☐ License other state NG/lh

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# PRELICENSURE NURSING PROGRAM (PON): NON-NURSE FACULTY RECORD

*To be submitted to KBN by PON Program Administrator within 30 days of appointment.*

**Submitted By:** _____ **Campus/Location:** _____
Name of College/University- DO NOT ABBREVIATE

**Type of Program:** ☐ **BSN** ☐ **ADN** ☐ **MEEP: PN & ADN** (Multiple Entry and Exit Program) ☐ **PN**

**Name of Appointee:**

_____
Last Name First Name Middle Name Maiden Name

**Social Security #:** _____ **Employment Status:** ☐ Full-Time ☐ Part-Time

**Any License #:** _____ **Compact License:** ☐ **Yes** ☐ **No** **State of Primary Residence:** ____ **Expires:** _____

**License has been verified on line at the appropriate Board:** ☐ Yes ☐ No

**Appointment Date (mm/dd/yy):** ____/____/____ **New position:** ☐ Yes ☐ No- Replacing (name)_____

**E-Mail Address:** _____@_____

**Educational Degrees:**

| College/University | Degree | Date Degree Awarded |
|---|---|---|
| _____ | _____ | Yr____ |
| _____ | _____ | Yr____ |
| _____ | _____ | Yr____ |

**Areas of Specialty:** _____
**Teaching Responsibilities Include What Specialties:** _____

**Answer the following questions with respect to this appointment**

**Non-Nurse Faculty, 201 KAR 20:310, Sec. 2 (4)(i)**

- Has appropriate academic & experiential qualifications for the program areas in which they participate? ☐ Yes ☐ No
- This non-nurse faculty is required to collaborate with a nurse faculty member in order to meet the nursing course outcomes. Who is that individual? _____

***I certify that the information contained herein is correct and complete to the best of my knowledge.***

_____ _____ _____ _____
**Signature of Appointee** **Date** **Signature of Nurse Administrator** **Date**

**Office Use Only: Review Date:** _____ **By:** _____ **KBN #:** _____ **Entered:** _____
Codes: ☐ None Other: _____ Letter Sent: ☐ Education Needed ☐ Name Change ☐ License other state NG/lh